



**B. TREATMENT DETAILS**Intent of Treatment: - Curative  Palliative 

Name of the hospital / Treatment Centre: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Proposed Treatment: \_\_\_\_\_

Name of the treating doctor: \_\_\_\_\_

Total cost of treatment (estimated): \_\_\_\_\_

(\_\_\_\_\_)

Name and signature of the treating doctor

(\_\_\_\_\_)

Treating doctor's / hospital's stamp

**C. FAMILY DETAILS**

Sr. No.	Name of family member	Relation to patient	Age	Occupation	Monthly income
1					
2					
3					
4					

**D. FINANCIAL DETAILS**

1. Total family income (in Rs.): PER MONTH: \_\_\_\_\_ PER ANNUM: \_\_\_\_\_

2. Patient is Working: - Yes: -  NO: -  Occupation \_\_\_\_\_ Monthly Income: -

3. \_\_\_\_\_ Family / \_\_\_\_\_ personal contribution (in Rs.): \_\_\_\_\_

4. Borrowed from relatives and friends (in Rs.): \_\_\_\_\_

5. Mediclaim eligible for / received from insurance company (in Rs.): \_\_\_\_\_

6. Medical reimbursement / aid from employer (in Rs.): \_\_\_\_\_

7. Are you registered for any government insurance scheme: - Yes: -  NO: - 

If \_\_\_\_\_ yes \_\_\_\_\_ give \_\_\_\_\_ details: \_\_\_\_\_

**E. DETAILS OF AID FROM OTHER TRUSTS/ORGANIZATIONS**

Sr	Name of trust / organization	Applied on	Amount sanctioned refused / pending / any other
1			
2			

3			
4			
5			

1. I declare that the details given by me on this form are true and correct.
2. I agree to comply with the terms, conditions and requirements as stipulated by the Foundation for any kind of aid given.
3. I agree to submit the receipt issued by the treating hospital(s) to the Foundation for any funds sanctioned.
4. I agree that in case of collection of required funds through advertisements / appeals in newspapers or any other media; any excess amount over and above the required medical expenses shall be used for the treatment of other cancer patients, and / or for facilities for the betterment of cancer patients as designated by the Foundation, and that I shall have no objection whatsoever for the same.
5. The Foundation should immediately be informed of any mishap to the patient.
6. I agree that my data can be used for ethical research by the Foundation as required.
7. I agree to share my personal information and photograph with donors as also for publicity use on social media or otherwise.
8. The decision of the Foundation shall be final and binding.

\_\_\_\_\_

Date

( \_\_\_\_\_ )

Signature of the applicant / patient

**F. INSTRUCTIONS**

1. Applications will be accepted only before treatment (surgery / chemotherapy / radiation).
2. Applications for the medical grant should be submitted either by the patient or by the patient’s immediate family members.
3. The applicant for the medical grant should be above 18 years of age.
4. Incomplete forms will be rejected and no correspondence will be entertained in this regard.
5. Submitting an application form to the Foundation’s office does not guarantee a medical grant from the Foundation. The Foundation’s decision to award medical grants, or otherwise, will be informed to the applicant. No explanation whatsoever would be given if the application is rejected.
6. Apart from the above instructions, it is hereby informed that the decision of the trustees would be final and binding on all matters and on all persons pertaining to the application.
7. Applicants can submit the form to person at the respective Centre from Monday to Friday, during working hours.

8. Application forms with incomplete / manipulated / false information, with an intention to mislead the Foundation will be rejected.

## G. MANDATORY DOCUMENTS

Select  documents that are being submitted along with this application.

1. Photo identity proof of patient (any one)

- a. Aadhar card       b. Pan Card       c. Voter ID card

2. Photo identity proof of Applicant (any one)

- a. Aadhar card       b. Pan Card.       c. Voter ID card

3. Address proof of patient (present or permanent address, any one):

- a. Aadhar card       b. Ration card       c. Electricity bill       d. Voter ID card

4. Latest income proof of all earning members:

a. If salaried (any one) -

Latest Income Tax Return       Latest salary slip       Current income certificate from tehsildar

b. If pensioner - updated pension passbook with entries for the past 12 months

c. If employed in an unorganized sector - self declared income proof

d. If self-employed - latest Income Tax Return

e. Updated Bank Passbook for past one year

5. Letter from the employer/s of all earning members mentioning whether the patient is eligible for any kind of

Medical assistance under a family scheme. If not, then a letter stating for the same

6. Certificate of the treating doctor - medical summary report stating diagnosis, stage of disease,

Approximate period of treatment, expected prognosis

7. Treatment cost certificate - signed by treating doctor & hospital administrator

8. Letter from the medical social worker of the treating hospital giving economic background

9. Copy of medical insurance policy

10. Patient's photo

**FOR OFFICE USE ONLY**

Form submitted by applicant on: \_\_\_\_\_ Submitted on: \_\_\_\_\_

Reviewed on: \_\_\_\_\_ Approved/ rejected on: \_\_\_\_\_

**Reviewed by Doctor:**

Name: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **Date:**      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Signature:**

**FUND DISTRIBUTION DETAILS**

<b>Date</b>	<b>Payment ref details</b>	<b>Sanctioned Amount</b>

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Chairman/ Trustee: \_\_\_\_\_

**Remark:-**